

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-004067

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

STATE FILE NUMBER

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION
BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY c. CITY OR TOWN d. STREET ADDRESS	
a. COUNTY St. Louis, Mo.		a. STATE South Carolina b. COUNTY Marion	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		c. CITY OR TOWN Marion	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Enroute City Hospital		d. STREET ADDRESS 202 Pickens	
3. NAME OF DECEASED (Type or print) First Middle Last William David Sanders		4. DATE OF DEATH Month Day Year January 12, 1963	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/3/1928
9. AGE (last birthday) 34	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat Cutter	11. BIRTHPLACE (City and state or country) Marion Co., So. Carolina	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Gary Sanders		13b. MOTHER'S MAIDEN NAME Alma Capps	
14. NAME OF HUSBAND OR WIFE Caroline		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W.# 2	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Caroline Sanders, Marion So. Carolina.	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dislocation of neck with compression on the cord; suffered when ran over by train (Frisco) in railroad yards in the rear of 1735 Austin, on January 11th, 1963, about 11:50 P.M. Accident Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. 802X-35 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) See Above	
20c. TIME OF INJURY Hour a.m. p.m. 11:50 p.m.	Month, Day, Year 1-11-63		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Railroad yards	20f. CITY, TOWN, OR LOCATION St. Louis, Missouri	COUNTY STATE
21. I attended the deceased from _____, to _____ and last saw him alive on _____. Death occurred at _____ 12:50 A _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Paul J. Simon		22b. ADDRESS 1300 Clark	22c. DATE SIGNED 1/14/63
23a. BURIAL, CREMATION REMOVAL (Specify) Removal	23b. DATE 1-14-63	23c. NAME OF CEMETERY OR CREMATORY Local	23d. LOCATION (City, town, or county) Marion So. Carolina.
24. FUNERAL DIRECTOR Albert H. Hoppe Inc., 4700 Washington, Blvd.		25. DATE RECD. BY LOCAL REG. JAN 14 1963	26. REGISTRAR'S SIGNATURE Hoard Smith M.D.

FEB 21 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Licensed Embalmer No. 7653

P. O. Address: St Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.